PATIENT FORMS (Total of 8 Pages)

Today's Date: _____

Patient Name: _____
FIRST MIDDLE LAST

Address: _____
STREET ADDRESS CITY/STATE ZIPCODE

Home Phone #: _____ **Cell Phone #:** _____

Email: _____

SS #: _____ **Birthdate:** _____ **Sex:** ◯ **M** **or** ◯ **F**

Communication Preference: ◯ Call ◯ Text Message ◯ Email

Do you have dental insurance? ◯ Yes **or** ◯ No

Are you…(PLEASE CIRCLE ONE):

◯ Married ◯ Separated ◯ Single ◯ Widowed ◯ NONE

EMERGENCY CONTACT INFORMATION

Name: _____ **Phone #:** _____ **Relationship to Patient:** _____

List any current medications you're taking below OR notate none if you are not taking any:

Medication	Dosage	Intake Frequency

MEDICAL HISTORY FORM

General Questions

Are you currently under a physician's care?	Yes No	If yes
Have you ever beeen hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you currently taking any medications, pills, or drugs?	Yes No	If yes
Are you currently taking or have ever taken Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use controlled substances?	Yes No	If yes
Do you use tobacco or tobacco products?	Yes No	If yes
Are you currently on a special diet?	Yes No	If yes

Allergies

Are you allergic to any of the following? Check all that apply.

- ☐ Acrylic
- ☐ Aspirin
- ☐ Codeine
- ☐ Latex
- ☐ Local Anesthetics
- ☐ Penicillin
- ☐ Sulfa Drugs

If *NO* allergies please notate here:

_____

If allergic to anything other than what is listed above please notate here:	Yes No	If yes

WOMEN ONLY

Women are you...

Pregnant or trying to become pregnant?	Yes No
Nursing?	Yes No
Taking oral contraceptives?	Yes No

Medical Conditions

Do currently have or have had any of the following? Check all that apply.

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxsis
- ☐ Angina
- ☐ Artificial HeartValve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Chemotherapy
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Diabetes
- ☐ Easliy Winded
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Heart Disease/Trouble
- ☐ Hepatitis A
- ☐ Herpes
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Osteoporosis
- ☐ Parathyroid Disease
- ☐ Radiation Treatments
- ☐ Renal Dialysis
- ☐ Rheumatism
- ☐ Shingles
- ☐ Sinus Trouble
- ☐ Stomach/Intestinal Disease
- ☐ Swelling of Limbs
- ☐ Tonsillitis
- ☐ Tumors or Growths
- ☐ Venereal Disease
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Arthritis or Gout
- ☐ Artificial Joint
- ☐ Blood Disease
- ☐ Breathing Problems
- ☐ Cancer
- ☐ Chest Pain
- ☐ Congenital Heart Disorder
- ☐ Cortisone Medicine
- ☐ Drug Addiction
- ☐ Emphesemas
- ☐ Excessive Bleeding
- ☐ Frequent Diarrhea
- ☐ GE Reflux/Heartburn
- ☐ Glaucoma
- ☐ Heart Attack/Failure
- ☐ Heart Pacemaker
- ☐ Hemophilia
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Irregular Heartbeat
- ☐ Leukemia
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Psychiatric Care
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes _____

Signature of Patient, Parent or Guardian:

X

Date:_____

DENTAL INSURANCE FORM

*PLEASE COMPLETE **ONLY** IF YOU HAVE **DENTAL INSURANCE***

If no insurance please draw an "X" through the page

Dental Insurance Company: _____

Patient Employer: _____

Mailing Address of Insurance Company:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

Subscriber Social S.S. # or Member ID:_____

Relationship to Patient *(circle one)*: Self Spouse Child Parent

*IF YOU HAVE **SECONDARY INSURANCE**..*

Insurance Company: _____

Member ID:_____

ASSIGNMENT AND RELEASE

I, THE UNDERSIGNED, HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER TO PAY DIRECTLY TO DR. ROBERT A. ZAMBROWSKI D.M.D. OR DR. MICHAEL A. ZAMBROWSKI D.D.S. ALL INSURANCE BENEFITS, IF ANY, DUE TO ME UNDER MY INSURANCE PLAN. I FURTHER AGREE TO PAY THE BALANCE OF THE CHARGES NOT PAID BY MY INSURANCE. I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION NECESSARY TO SECURE PAYMENT OF BENEFITS. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

SIGNATURE: _____DATE:_____

INFORMED CONSENT FOR DENTAL PROCEDURES

You, the patient, understands that I have the right to accept or reject dental treatment recommended by my dentist and acknowledge that prior to consenting to the recommended treatment by signing below, I have been fully advised of and I have carefully considered the anticipated benefits and possible known risk of the recommended procedure, alternative treatments, or the option of no treatment, as they are presented to me.

I have been advised and I understand that individual reactions to treatment cannot be predicted, and by consenting to the treatment, I am acknowledging my willingness to accept all risk and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. I understand that the success of my dental treatment depends upon my cooperation in keeping scheduled appointments, at this office or with other recommended dentist or specialist, following all pre and post treatment instruction, including oral hygiene and dietary instructions, taking prescribed medication, and reporting to this office any changes in my health status. I understand that failing to follow the advice of my dentist may increase the chance of a poor outcome.

Please read the items below, initial where indicated, and sign at the bottom of the form.

1. **Treatment to be Provided**

   I understand that during my course of treatment that the following ***MAY*** be provided:

   Examinations, Preventive Services, Restorations, Crowns and Bridges, Root Canal Therapy Extractions, Radiographs, Other

   Patient Initials_____

2. **Drugs and Medications**

   I have been advised and I understand that antibiotics, analgesics and other medications can cause allergic reaction causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reactions). I will inform the office of any such known reactions to the best of my knowledge. I have advised the dentist of any and all medication of any type that I currently am taking, and I acknowledge that my failure to advise the dentist may have unforeseen medical consequences for me.

   Patient Initials_____

3. **Local Anesthesia**

I understand that there are some risks in the administration of local anesthesia. Most risk are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur, they might include loss of, or disturbed sensation of the tongue and/or on the lip on the side of the injection. If this occurs, it is often temporary, and normal sensation usually returns in several days. However, in very rare cases, the loss of sensation may extend for a longer period or become permanent. In addition, injection of a local anesthesia into the body may result in a rare allergic reaction.

Patient Initials_____

4. **Changes in Treatment Plan**

I have been advised and I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_____

5. **Insurance Communication**

I give permission to the dental office to communicate with and bill my dental insurance provider for any treatment to me, if applicable.

Patient Initials _____

I understand that dentistry is not an exact science and that, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Patient Signature_____**Date**_____

FINANCIAL AGREEMENT

ACCEPTED FORMS OF PAYMENT: We accept cash, checks, VISA, MASTERCARD, & DISCOVER. We unfortunately do not accept American Express. We also offer financing through Care Credit.

For dental treatment requiring *LAB WORK OR ANY RESTORATIVE TREATMENT* involving multiple steps (ex: crowns, bridges, root canals, dentures, or implants etc.) we ask that ½ of the fee is due at the first appointment with the remaining balance due at delivery.

For dental treatment requiring a *PRE-AUTHORIZATION OF BENEFITS* (ex: crowns, bridges, root canals, dentures, or implants etc.) we ask that ½ of the fee that is not covered by your insurance be due at the first appointment with the remaining balance due at delivery.

PATIENTS WITHOUT DENTAL INSURANCE: Payment in full is expected at the time of services are rendered.

EMERGENCY/URGENT TREATMENT WITH OR WITHOUT INSURANCE: Payment in full is expected at the time of services rendered.

PATIENTS WITH DENTAL INSURANCE: As a courtesy to you we will file your insurance company. Please be advised that your agreement with your insurance carrier is a private one and that ultimately you are responsible for payment. If an insurance carrier has not paid a claim within 60 days of billing our fees are due in full and payable from you. Should our office receive a payment from your insurance after you have paid a prompt refund will be issued to you.

Most insurance companies will respond within 2-3 weeks. After your insurance pays any remaining balance is your responsibility. We will mail you a statement and payment in full is due within 21 days of receiving your statement. We do not carry account balances month to month. We ***REQUIRE*** you to pay the ***ESTIMATED*** "patient portion" at the time of service. This may include a deductible and/or an ***ESTIMATED*** percentage of each procedure.

NOTE: If your insurance reimburses the ***SUBSCRIBER (YOU)*** payment is due at the time of service.

PROMPT PAYMENT: Just as we make every effort to accommodate you when you are in need of dental care, we expect that you will make every effort to pay your bill promptly. We reserve the right to charge a $20.00 per month billing charge on all past due accounts.

Patient Name (PRINT): _____ **Date:** _____

Responsible Party Signature: _____ **Relationship to Patient:** _____

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I _____ **(PRINT PATIENT/GUARDIAN NAME)** have received or been offered a copy of Zambrowski General Dentistry's Notice of Privacy Practices.

Signature of Patient/Representative:_____ **Date**: _____

Relationship to Patient **(circle one)**: Self Child Spouse Caregiver Parent

PATIENT INFORMATION DISCLOSURE

May we discuss details regarding your care, treatment, billing/insurance information, and appointment information with someone else other than you?

Examples: Your husband/wife, parent, child, friend, etc.

PLEASE CIRCLE: **YES** **OR** **NO**

If **YES**, you must list the name and relationship of each individual below

Name (PRINT)	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature of Patient/Representative: _____ **Date**: _____

Relationship to Patient **(circle one)**: Self Child Spouse Caregiver Parent

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barrier

__An emergency situation

__Other (Please specify): _____